Amy T. Bandy, D.O., F.A.C.S.

Plastic and Reconstructive Surgery

Nasal History Questionnaire

Patient Name:____Date:____________

Do you have breathing problems: ☐ Yes ☐ No

If yes, when did it start?____

Do you suffer from headaches: ☐ Yes ☐ No

Do you have allergies: ☐ Yes ☐ No

If yes, list:____

____

Do you have trouble breathing through your nose: ☐ Yes ☐ No

Do you find yourself breathing through your mouth: ☐ Yes ☐ No

Do you feel pressure around your sinus area: ☐ Yes ☐ No

Do you have post nasal drip: ☐ Yes ☐ No

If yes, what color is the drainage:____________________________________

Do you suffer from nose bleeds: ☐ Yes ☐ No

Have you recently sustained injury to your nose: ☐ Yes ☐ No

If yes, what is the date of the accident:__________________________________

What type of accident was it:____

____

Did you seek medical attention: ☐ Yes ☐ No

If yes, explain what type of treatment, as well as name of the attending physician:

____

____

Were x-rays taken: ☐ Yes ☐ No

If yes, where:____

Have you had any previous nasal surgeries: ☐ Yes ☐ No

If yes, list the names of the surgeon(s) and facility:________________________

____

Signature:____Date:____________